Children's
Advocate
Report

A Summary of Child Death Reviews:
August 1996 to December 1998

February 2001

The Children's Advocate is an officer of the Legislative Assembly of Saskatchewan and acts pursuant to *The Ombudsman and Children's Advocate Act*. This review was conducted in accordance with this legislation.

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REVISION: *A Summary of Child Death Reviews: August 1996 to December 1998*

Please note that a revision is required to the text on pages 5, 18 and 20, Figures 3 and 5 and Table 1 (Appendix A). For the year 1998, the one death recorded as Undetermined (children in care), in the 6-11 year-old age category has been coded by Vital Statistics, such that it falls within a Natural Cause death classification. This information is referenced on pages: 5, 18, 20 and 35.

Printed: February 2001. Revision Date: May 2, 2001.

Executive Summary

This report provides a summary of the themes and issues identified in child death reviews conducted by the Children's Advocate Office (CAO). The children whose deaths were reviewed died between August, 1996 and December 1998 (4 in 1996, 25 in 1997, and 33 in 1998) in Saskatchewan. All of these children were at the time of their death or in the 12 months preceding their death receiving services from the Department of Social Services (DSS) pursuant to *The Child and Family Services Act*, or the *Young Offenders Act* (Canada), or were attending a facility or a family child care home licensed under *The Child Care Act*.

In 1996, the DSS and the CAO recognized that more independent and publicly accountable reviews of child deaths were required. A protocol was established whereby the CAO is routinely notified when children die in the above outlined circumstances. Child Death Reviews are intended to provide information that will prevent child deaths, improve child-serving systems and promote public accountability.

This report examined the deaths of a limited number of our most vulnerable children. The CAO reviewed 10.7 percent of the deaths of all Saskatchewan children (under age 22) in 1997 and 14.9 percent of all child deaths in 1998.

Of the child deaths reviewed, 13 children (0 in 1996, 3 in 1997 and 10 in 1998) were in the care of the Minister of Social Services when they died. Seven of these 13 died of natural causes, while the remaining six children died as a result of suicide, drowning, homicide and accidents. The cause of one death was undetermined.

Forty-nine (49) of the deaths reviewed were children who were not in the care of the Minister when they died (4 in 1996, 22 in 1997 and 23 in 1998). Of these children who died, 18 deaths were accidental, ten deaths were suicides, seven deaths were attributed to SIDS, seven deaths were the result of natural causes, six deaths were homicides, and one death was undetermined.

The CAO brought individual issues concerning services for children to the attention of the DSS on a case-by-case basis. In addition, eight themes and issues emerged from this set of reviews:

1. Sudden Infant Death Syndrome (SIDS) remains one of the leading causes of death for infants. The CAO recommended that the Coroner's Branch consider developing and implementing a SIDS protocol and the Chief Coroner has agreed to proceed with this initiative.

2. Although the results were inconclusive, there were indicators that in seven of the infant deaths an adult was sleeping with the infant at the time of death. The CAO requested that the Action Plan for Children ensure that information about the dangers of adults co-sleeping with infant children, particularly when intoxicated, be provided to all new parents.

3. The presence of FAS or the effects of prenatal exposure to alcohol was a significant concern. The CAO welcomed the additional funding provided by government to prevent FAS and to provide increased services for children affected by FAS.

4. The number of children who had suffered assaults during their lives and/or who died at the hands of family and caregivers was disturbing. The CAO identified the need for ongoing public education about the importance of reporting potential abuse of children to the appropriate authorities. A climate where the inclination is to report rather than ignore assaults on children must be fostered.

5. Several children died by suicide. The CAO recommended that collaborative case planning occur for children receiving services from both the DSS and a Heath District and that a mechanism to follow-up on plans be implemented.

6. There continues to be a general perception that there are difficulties for youth to access addiction services. The CAO is concerned that children and youth do not have access to the same services as adults.

7. The concerns raised by the CAO in previous reports (*Child Death Review: Karen Rose Quill* and *Children and Youth in Care Review: LISTEN to Their Voices*) regarding noncompliance by the DSS to legislated requirements and policy standards were noted in several of the files that were reviewed for this report. The DSS has committed to and is actively working towards improving compliance and thereby improving the quality of services provided to children and families.

8. There was a lack of information sharing and service follow-up between the DSS and some Indian Child and Family Services Agencies. A Protocol for Case Transfer has now been signed between the DSS and ten ICFS Agencies and the effectiveness of these protocols is to be examined in the future.

Child Death Reviews are a sobering reminder of the need to ensure that our child serving systems are taking action to intervene appropriately to protect children from known risk factors which threaten their health, well-being and indeed their very existence. This report highlights the need to continue to examine child deaths and to learn what we can to more effectively prevent child deaths. The challenge is to ensure that the issues raised in this report are addressed.

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Part 1
Introduction

Across Canada, and in several countries around the world, the review of child deaths is leading to an increased awareness of the factors that contribute to deaths of children. In many jurisdictions, this has resulted in communities and governments implementing changes to make communities safer for children. This is also happening in Saskatchewan.

The Children's Advocate Office (CAO) in Saskatchewan conducts comprehensive reviews of the deaths of a limited number of children. The reviews offer observations, findings and recommendations designed to prevent child deaths, impact child serving systems and promote public accountability.

This report provides a summary of themes and issues identified by the CAO based on the CAO review of 62 deaths that occurred between August 1996 and December 1998 (4 in 1996, 25 in 1997 and 33 in 1998) in Saskatchewan.

All of us want to ensure that all children have a chance to live happy and contented childhoods, reaching their full potential as adults. We owe no less to them. It is hoped that what has been learned from these child deaths will help give children increased opportunities to realize their potential.

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Part 2
Authority

Children's Advocate: Authority and Mandate

The Children's Advocate is an officer of the Legislative Assembly of Saskatchewan and acts pursuant to *The Ombudsman and Children's Advocate Act*. The Children's Advocate promotes the interests of, and acts as a voice for children when there are concerns about provincial government services. The Children's Advocate engages in public education, works to resolve disputes, and conducts independent investigations. The Children's Advocate also recommends improvements to programs for children to the government and/or the Legislative Assembly of Saskatchewan. The mission of the Children's Advocate is to ensure that the rights of children and youth are respected and valued in our communities and in government practice, policy and legislation.

Section 12.6 inter alia of *The Ombudsman and Children's Advocate Act* provides that:

(2) The Children's Advocate shall:
- (a) become involved in public education respecting the interests and well-being of children;
- (b) receive, review and investigate any matter that comes to his or her attention from any source, including a child, concerning:
  - i) a child who receives services from any department or agency of the government;
  - ii) a group of children who receive services from any department or agency of government; and
  - iii) services to a child or to a group of children by any department or agency of the government;
- (c) where appropriate, try to resolve those matters mentioned in clause (b) that come to his or her attention through the use of negotiation, conciliation, mediation or other non-adversarial approaches; and
- (d) where appropriate, make recommendations on any of those matters mentioned in clause (b).

Saskatchewan, 1979. As am. by s.s. 2000

Authority to Conduct Child Death Reviews

Child Death Reviews (CDRs) are conducted by the CAO in accordance with Section 12.6 (2)(b)(iii) of *The Ombudsman and Children's Advocate Act*, which states that the Children's Advocate shall "receive, review and investigate any matter that comes to his or her attention from any source, including a child, concerning services to a child or to a group of children by any department or agency of the government." The Children's Advocate has the authority to require any person to provide information, documents or things regarding any matter being investigated. She is further authorized to summon and examine under oath any person who is able to provide information relating to the matter being investigated.

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Part 3
Background

Prior to November 1996, the Department of Social Services (DSS) contracted with individuals, external to the DSS, to review a few of the deaths of children who died while in their care or who had received services from the DSS within the previous 12 months. Three or four of these deaths were reviewed each year. These reviews were conducted when the death was particularly complex or controversial. There was limited public reporting on the outcomes of these reviews. The Provincial Ombudsman also, from time to time, conducted an independent investigation of a complaint related to a child death.

As a result of growing awareness of the need for increased public accountability, the DSS and the CAO recognized that more independent and publicly accountable reviews of these child deaths were required. The DSS and the CAO recognized that independent external reviews would provide valuable insight into how child deaths could be prevented. Various options were explored. Due to the legislative authority and independence of the Children's Advocate, it was agreed that the CAO was the most appropriate office to conduct child death reviews and publicly report on the deaths.

The DSS adopted a new child death review policy in November 1996. The intent of the policy was "to satisfy the department's need to be accountable in the services provided to children, youth and families, and to ensure that the public interest in protecting children and youth is met." (Saskatchewan Social Services, 2000, February-Revised).

In November 1996 a protocol was also established between the CAO and the DSS. The CAO agreed to provide the independent, external reviews of the death of a child when a referral was made by the DSS.* The reviews would examine the deaths of children who were, at the time of their death or in the 12 months preceding their death, receiving services from the DSS pursuant to *The Child and Family Services Act*, or the *Young Offenders Act* (Canada), or were attending a facility or a family child care home licensed under *The Child Care Act*. This initial agreement was for the CAO to review the deaths of the three or four children per year that the DSS identified as particularly complex.

*Note: The CAO reviewed four child deaths that occurred in 1996. One of these deaths occurred in August 1996. Although the protocol was not established with the DSS until November 1996, the CAO reviewed the August death because the DSS sent notification to the CAO.

Karen Rose Quill

In September 1997, Karen Rose Quill, a 20-month old child, died while in the care of the Minister of Social Services. At the request of the Minister, the CAO reviewed the DSS involvement in Karen's life and the circumstances of her death.

A public report *Child Death Review: Karen Rose Quill* was completed in June 1998. This was a comprehensive report that included many system-based recommendations intended to improve the services and care provided to all children. More specifically, these recommendations were aimed at improving services to children, improving the protection of children and reducing the number of child deaths.

The report's 27 recommendations were provided to the Minister of Social Services in June 1998. The DSS responded to the 27 recommendations in two *Progress Reports: Response to the Children's Advocate's Report on the Death of Karen Quill*, dated February 3, 1999 and December 2, 1999. The two reports were provided to the CAO and detail actions taken by the DSS in response to the recommendations (See Appendix B). Progress and changes have been initiated by the DSS in regard to the issues identified in the Quill Report.

The review of Karen Quill's death made it clear that it was necessary to review the death of every child in order to reflect on how services are provided to those children who are our most vulnerable citizens. The CAO made the decision to review the deaths of all children who die while in the care of the Minister of Social Services or who had received services in accordance with the November 1996 protocol. At the request of the CAO and with the support of the DSS, the number of reviews undertaken by the CAO increased from the anticipated three or four per year to approximately 30 per year.

Children and Youth in Care Review: LISTEN to Their Voices

Prompted by the death of Karen Quill in 1997, the Minister of Social Services requested that the Children's Advocate undertake a review of the needs of children living in foster care. The need for a comprehensive and public review of the services provided for children and youth living in foster care was also identified by a number of concerned individuals and groups across Saskatchewan, particularly many of the young people already in care.

Completed in April of 2000, the goal of the *Children and Youth in Care Review: LISTEN to Their Voices* was to develop recommendations to assist the government in creating positive change for children in care in Saskatchewan.

The Review consisted of an extensive examination of the literature, public and individual consultations with more than 1100 Saskatchewan residents and a review of a random sample of files of children in care. Ten themes emerged during this Review. The Review generated seven primary recommendations and 45 sub-recommendations that focus on improving services for children in care. (See Appendix C).

The Minister of Social Services is to publicly respond to the recommendations in the report in the spring of 2001.

Part 4
Process for Conducting a Child Death Review

The 1996 – 1998 CDR Process

For the purpose of this report, the CAO reviewed the services provided to each child by the DSS. The CAO received notification of the death of each child from the DSS and the Coroner's Branch, Department of Justice.

The CAO Child Death Review process begins upon receipt of a Social Services' Child Death Report. These are regional reports prepared by a DSS senior supervisor or DSS program manager. The reports review the death of each child in relation to the services provided by the DSS to that child and his or her family.

The DSS has demonstrated a commitment to understand each child's death. The regional reports frequently recommend improvements to DSS policies and practices. For the most part, the CAO has supported the recommendations that the DSS has identified.

Following the receipt of the Social Services Child Death Report, the CAO sent a notice of investigation to the DSS pursuant to *The Ombudsman and Children's Advocate Act*.

In conducting each Child Death Review, the CAO reviewed:
- the information provided by the Coroner's Branch,
- the original DSS file material, and
- interviewed staff where clarification was required.

The service provided was examined for consistency with existing policy and practice. Upon completion of the individual review, notice of the CAO observations, findings and recommendations was provided, primarily to the DSS. The CAO invited representation and discussion in accordance with *The Ombudsman and Children's Advocate Act* prior to finalizing the review and concluding each individual file.

Purpose of CDRs

Child Death Reviews advance thorough, comprehensive reviews which serve to prevent child deaths, impact child serving systems and promote public accountability.

The child deaths that occurred in 1999 and 2000 will be reviewed using a revised and expanded review format.

Principles

A set of principles was developed to guide the CAO in this sensitive work. The CAO will:

- conduct reviews in a manner that respects the inherent dignity of all persons
- be as timely, inclusive and accountable as possible
- honor the privacy of children and their families
- promote quality services for children and their families.

In June 2000, the CAO, along with the coroners, medical examiners and other practitioners responsible for Child Death Reviews in Canada, adopted a set of national principles to guide child death review work. This Federal/Provincial/Territorial Working Group on Child Death Review collectively agreed that thorough comprehensive child death reviews will serve to prevent further child deaths, impact child serving systems and promote public accountability. The principles established for conducting CDRs are:

- that the agencies conducting the reviews be external to and independent from the organizations and agencies subject to the review
- that the reviewers have statutory powers to ensure access to information, the authority to make recommendations, and the ability to monitor compliance with recommendations, and
- that the reviewers have the ability to make public reports and utilize a multi-disciplinary approach (Federal/Provincial/Territorial Working Group Child Death Review, June 2000).

Consistent with these national principles for Child Death Reviews, the Children's Advocate in Saskatchewan:

- is an officer of the Legislative Assembly, external to and independent from those departments and agencies who provide services to children,
- has the statutory power to ensure access to information, the authority to make recommendations and monitor compliance,
- is committed to making the results of the reviews public, and
- is currently developing a multi-disciplinary review team.

Child Death Advisory Committee

In addition to the review of specific, individual child deaths, an interdisciplinary Child Death Advisory Committee, chaired by the Children's Advocate and the Chief Coroner for Saskatchewan, was created in 1996. This Committee includes representatives from several provincial government departments, First Nations organizations, the Metis Nation of Saskatchewan, the Royal Canadian Mounted Police (RCMP), the Saskatchewan Police Commission, the Saskatchewan Institute on Prevention of Handicaps, and the College of Physicians and Surgeons. The Committee identified the following objectives:

- to examine the process used in Saskatchewan to report and review deaths of children,
- to promote mechanisms that ensure that a comprehensive analysis of child deaths occurs regularly in the province, and
- to advise government on the implementation of any recommendations regarding practice or policy questions arising from a comprehensive analysis of child deaths.

This Committee continues to meet to work on these objectives. It has become clear that while many Saskatchewan organizations examine or review different sets of child deaths or different aspects of most child deaths, there is no single body that reviews or examines, in a systematic way, all child deaths.

In 1999, the Child Death Advisory Committee observed that, in Saskatchewan, the CAO is the only agency dedicating resources to the review and analysis of selected deaths of children. Presently the CAO is reviewing approximately 15 percent of Saskatchewan child deaths. Other agencies, including the Coroner's Branch, also review some child deaths in special circumstances. The Committee recommended that Saskatchewan establish an independent-of-government mechanism to review the deaths of all children. This recommendation has been brought to the attention of government and the Committee is preparing a more formal submission for further consideration.

Part 5
This Report

Which Children Are Included In This Report?

This report provides a summary of the themes and issues found in the reviews of 62 children who died between August 1996 and December 1998 (including the review of Karen Quill). The child deaths reviewed include four deaths in 1996, 25 deaths in 1997 and 33 deaths in 1998. All of these child deaths were referred to the CAO by the DSS. These children were, at the time of their death or in the twelve months preceding their death, receiving services from the DSS pursuant to *The Child and Family Services Act*, or the *Young Offenders Act* (Canada), or were attending a facility or a family child care home licenced under *The Child Care Act*. The services provided by the DSS extended to youth up to the age of 21 and, in one instance, beyond the age of 21. (Note: The one death of the youth over the age of 21 was included in the report because the youth was still receiving services from the DSS.)

Notification was received from the DSS on a total of 65 deaths of children between August 1996 and December 1998. Reviews of three of these child deaths are yet to be finalized (due, in one case, to outstanding civil legal proceedings; in another, to the completion of a multi-agency review; and to a possible coroner's inquest in the third). These three deaths are not included in this report.

This report provides a summary of the issues identified in the course of the individual reviews. The specific, individual findings are not detailed. Any specific safety, policy, practice or legislative issues that were found were brought to the attention of the DSS or other agencies prior to concluding the individual review. Where the individual review reflected issues that were the same as or similar to those presented and published in the *Child Death Review: Karen Rose Quill* or the *Children and Youth in Care Review: LISTEN to Their Voices* no further recommendations were made to the DSS. All the deaths included in this report occurred prior to January 1999, when the DSS agreed to implement significant policy and practice changes in response to the Quill Report.

Classifications of Deaths

The Coroner's Branch classifies approximately 50 percent of all child deaths in the province by manner of death. The five classifications used by the Coroner's Branch are Natural, Accidental, Homicide, Suicide and Undetermined. The Coroner classifies a death as Undetermined where no conclusion can be reached as to the manner of death.

While the Chief Coroner includes deaths attributed to SIDS in the classification of Natural deaths, for the purposes of this review the CAO has listed the SIDS deaths as a separate category.

The Chief Coroner concludes his review and makes any reports, including autopsy results, available to the CAO. The Chief Coroner reviews each death to determine its cause and manner or the "who, when, where and how" of the death. The CAO reviews each death to ask "why" the child died and considers the death in a social context to enhance early intervention and prevention through proactive change.

Part 6
General Findings

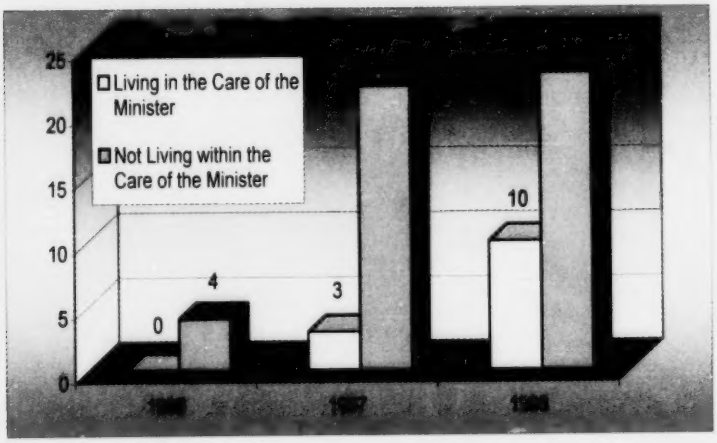
In reviewing the deaths outlined in this report, the CAO found that the services provided by the DSS to 29 of the children and their families either met or exceeded the DSS standards. In 32 of the files reviewed (excluding Karen Quill), case management concerns were raised. This was done primarily in the form of observations and findings. The findings often reflected issues previously identified in both the Quill Report and the Children and Youth in Care Review. While some of these issues were specific to children in care, most related to more broadly defined child welfare services.

Therefore, when the child death review reflected findings and recommendations previously set out in the Quill Report or the Children and Youth in Care Review, no additional formal recommendations were made.

In a small number of reviews that were conducted, formal recommendations were made. These recommendations were not previously identified in either of the Quill or Children and Youth in Care Review reports. These recommendations are detailed within the text of this report.

Who Are These Children?

Figure 1. CAO Child Death Reviews showing Type of Care Arrangement with the Minister of Social Services, 1996-1998. N=62



Of the deaths reviewed for this report, the following is known:

- 38 children were male, while 24 were female
- 36 children were status First Nations children
- 13 were in the care of the Minister of Social Services at the time of their death, while 49 were receiving services from the DSS at the time of their death or in the 12 months preceding their death.

Causes of Death

The leading cause of death was by Accident (21). The second leading cause of death was Natural Causes (14), followed in number by Suicide (11), Homicide (7) and SIDS (7). The cause of death remains Undertermined in two cases.

Accidents
Of those 21 children who died by accident, 10 died in motor vehicle incidents, two died in house fires, two by drowning, two by drug overdose, and five by other causes.

Natural Causes
Of the 14 children who died of natural causes, 13 were medically fragile. The natural cause of death was undetermined for one child.

SIDS
Seven child deaths were classified as SIDS. Please refer the section of this report on SIDS and co-sleeping for additional information (pages 23 and 24).

Suicide
Of the 11 suicide deaths, five children shot themselves and six children hanged themselves.

Homicide
Of the seven children who were the victims of homicide, four died of stab wounds, two died of assaults, and one died by strangulation.

Comparison to Provincial Child Deaths

These deaths reviewed by the CAO for this report represent a fraction of the total number of children who died in Saskatchewan during this time period. As stated earlier in this report, the CAO reviewed the deaths of children who were, at the time of their death or in the 12 months preceding their death, receiving services from the DSS pursuant to *The Child and Family Services Act*, or the *Young Offenders Act* (Canada), or were attending a facility or a family child care home licensed under *The Child Care Act*.

In 1997, a total 234 children and youth under the age of 22 died in Saskatchewan. The CAO reviewed 25 of these deaths, representing 10.7 percent of the total provincial child deaths. In 1998, a total 215 children and youth died in Saskatchewan. The CAO reviewed 32 of these deaths representing 14.9 percent of the total provincial child deaths. One death of a youth over age 21 was also reviewed in 1998.

Figure 2 compares the number of provincial child deaths by cause of death with the deaths reviewed by the CAO during 1997 and 1998. A complete breakdown of the deaths by age and cause of death is provided in Table 1 (Appendix A of this report). (Note that the four deaths which occurred in 1996 have not been included as 1996 was not a complete review/reporting year and a comparison is therefore not possible.)

Figure 2. Number of Deaths of Children From Birth to 21 Years of Age in Saskatchewan: CAO Deaths Reviewed[1] and Total Provincial Deaths[2], 1997[4]

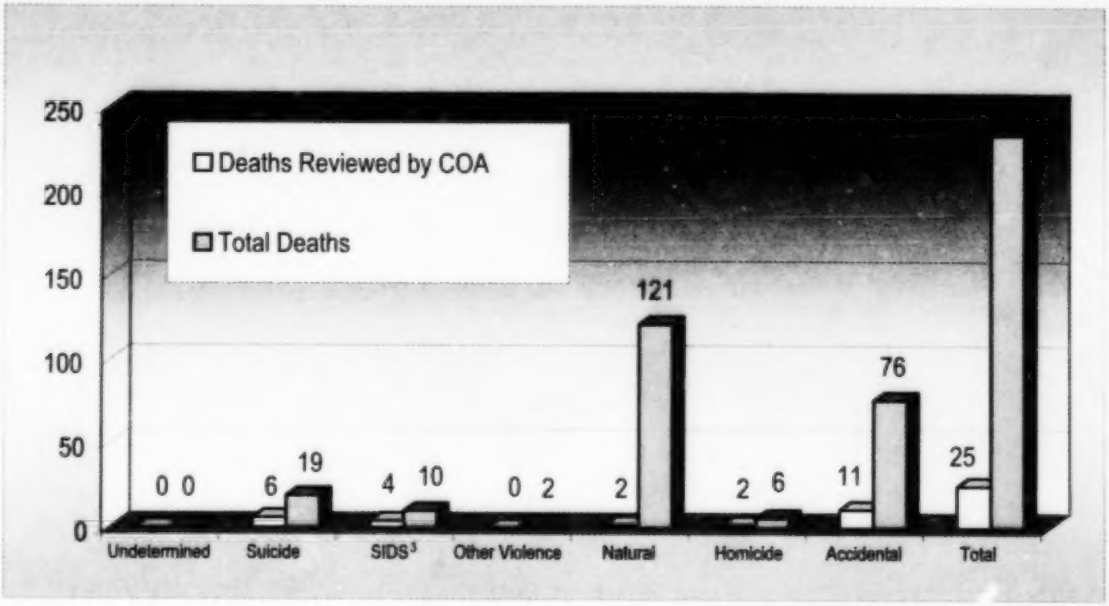
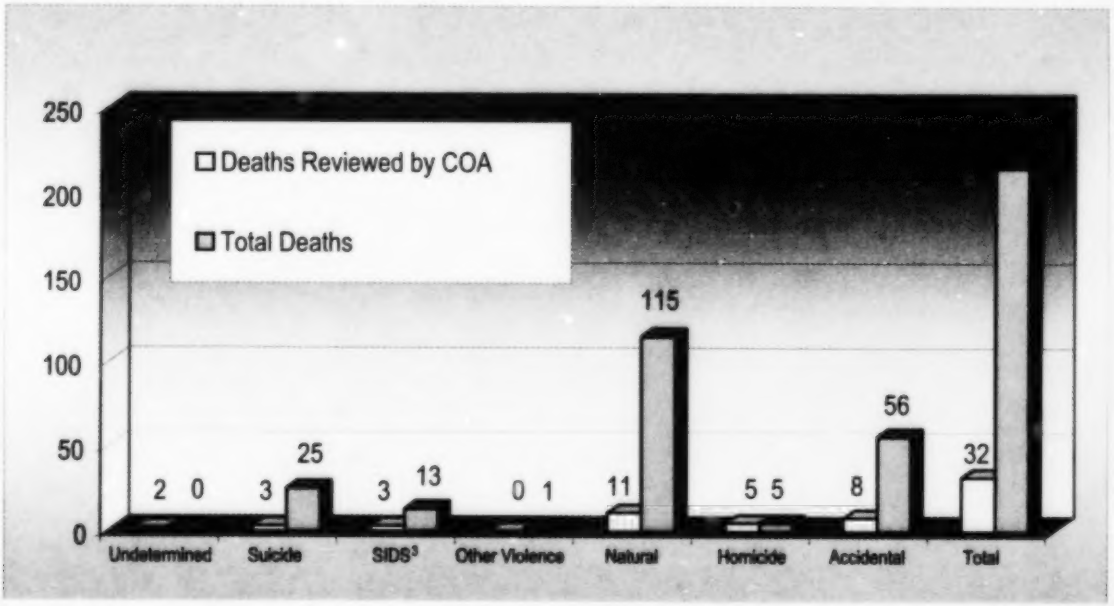


Figure 3. Number of Deaths of Children From Birth to 21 Years of Age in Saskatchewan: CAO Deaths Reviewed[1] and Total Provincial Deaths[2], 1998[4]



[1]Not including the four deaths which occurred in 1996 and the death of one youth which occurred in 1998 where the youth was over age 21 but still receiving services from the DSS.

[2]Source: Saskatchewan Health, Corporate Information and Technology Branch (Figure prepared with the assistance of the Saskatchewan Institute on Prevention of Handicaps, 2000.)

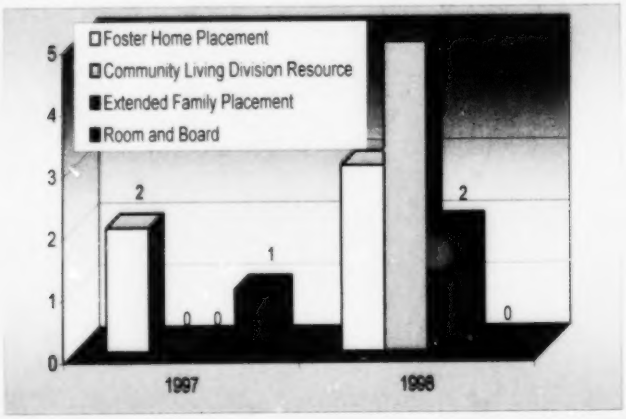
[3]For provincial data, includes sudden deaths of infants, cause unknown.

[4]An explanation of the reasons for numerical discrepancies is provided in Appendix A.

Children in the Care of the Minister

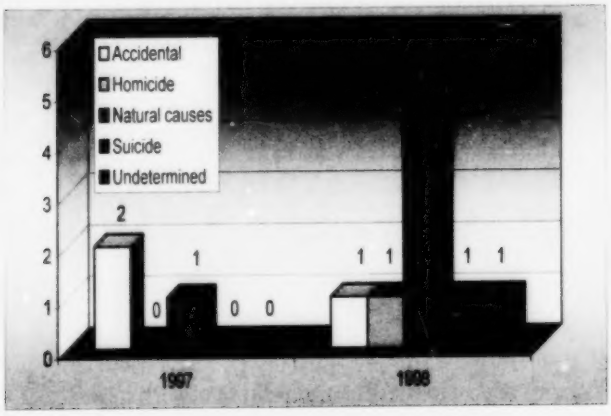
When a family experiences problems that are of a serious nature and safety cannot be ensured within their home, they may be placed in out of home care or in the care of the Minister. A majority of children are placed in foster care. However, some are placed with extended family, in group homes, or residential facilities. Youth who are over the age of 16 may choose to live independently. Children are returned home as soon as their families have addressed the risks to safety or the treatment needs. However, there are situations where children and youth remain in care until they are 21 years of age (Saskatchewan Social Services, 2000).

Figure 4. CAO Child Death Reviews showing Living Arrangement at Time of Death for Children in the Care of the Minister of Social Services. 1997-1998. N=13



Of the 62 child deaths reviewed, 13 children were in the care of the Minister of Social Services when they died (0 in 1996, 3 in 1997 and 10 in 1998). Figure 4 provides a breakdown of the type of care arrangement for each of these children. Five of these children were placed in DSS approved foster homes. Of these five, three were medically fragile children whose life expectancy was shortened by the nature of their medical condition. One child committed suicide and one was Karen Quill.

Figure 5. CAO Child Death Reviews showing Cause of Death for Children in the Care of the Minister of Social Services. 1997-1998.



Five more medically fragile children were living in homes approved as resources by the Community Living Division of the DSS. Children in these resources are entitled to the same level of care as other children in the care of the Minister. One young person was living in an approved room and board placement when he died by drowning. The remaining two children were living with extended family members by agreement with the DSS. One of these children died as a result of a homicide and one died in a car accident.

Figure 5 provides a breakdown of the cause of death for children living in the care of the Minister of Social Services.

Of the children who died while living in the care of the Minister of Social Services, seven deaths were the result of natural causes, three deaths were accidental, one death was a homicide, one death was a suicide and one death was undetermined.

Children Not in the Care of the Minister

The DSS provides services to children and youth residing in their own homes or with extended family. These services may include the services provided by one or more of the programs listed below. (Note: information for program descriptions below was provided to the CAO by the DSS as well as through information available on the DSS website).

Adoption
Services assist and support families who apply to establish a legal family relationship or "adopt" a child.

Child Protection
Services are provided to families when a child is found to be in need of protection as defined by Section 11 of *The Child and Family Services Act*. This includes situations of physical, sexual or psychological abuse, failure to provide essential medical treatment, failure to address serious developmental needs, domestic violence, child abandonment and children under 12 years who commit an offense.

In the majority of situations the DSS works with families who are caring for their children in their own homes to improve the quality of parenting and ensure safety. When a family experiences problems that are of a serious nature and safety cannot be ensured within their home, they may be placed in the care of the Minister.

In addition, 18 Indian Child and Family Services Agencies are in operation across the province and provide child protection services to First Nations children and families living on-reserve.

Community Living Division (CLD)
The CLD provides services to families who are caring for children and youth with intellectual disabilities. Programs support the physical, emotional, and social needs of clients and assist them to live and function as independently as possible within their own communities.

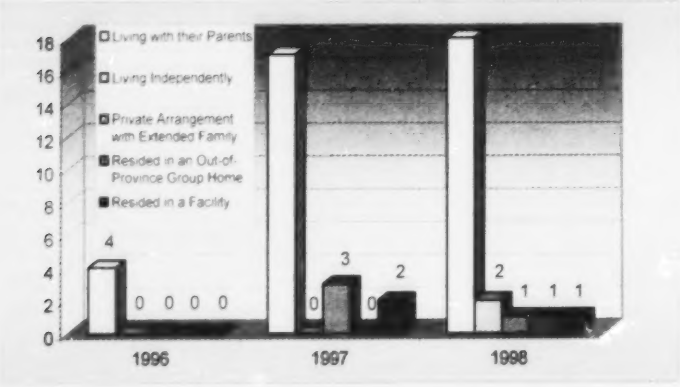
Teen and Young Parent Program
This is a voluntary program that assists young adults who are pregnant or parenting children.

Young Offender Programs
Services are provided to youth 12 to 17 years of age who have been convicted of a criminal offense and sentenced to a period of probation or custody. The program consists of secure and open custody as well as community-based programs. Youth may remain involved in the program beyond the age of 18 if their period of probation or custody has not been completed.

16 and 17 Year Old Program
The program assists youth to gain independence and provides counseling and residential services to youth that are at risk. The program combines child welfare, youth programming and income security.

Of the 62 child deaths reviewed, 49 children were, at the time of their death or in the twelve months preceding their death, receiving services from the DSS and were not living in the care of the Minister of Social Services. This number included four deaths in 1996, 22 deaths in 1997 and 23 deaths in 1998.

Figure 6. CAO Child Death Reviews showing Living Arrangement at Time of Death for Children Not in the Care of the Minister of Social Services, 1996-1998. N=49



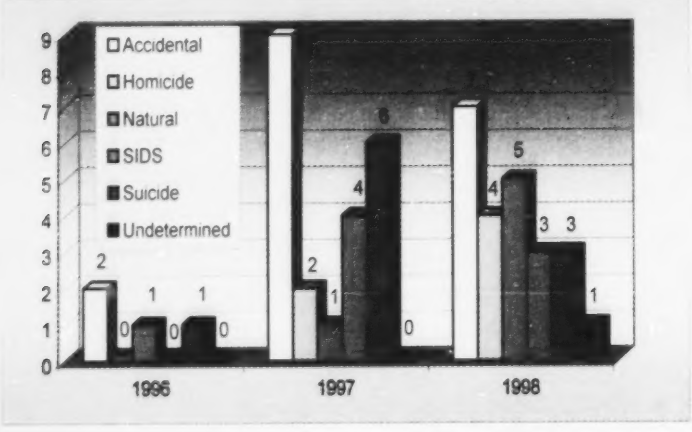
A facility could include but is not limited to hospitals, correctional facilities, penitentiaries, etc.

Figure 6 provides a breakdown of the type of living arrangement for each of these children. The majority of these children, 39, were living with their parents at the time of their death. Four children were living with extended family; three were living in a facility such as a hospital, correctional facility or penitentiary; two were living independently and one was living in an out of province group home.

Figure 7 provides a breakdown of the cause of death for children not living in the care of the Minister of Social Services.

Of the children who died, 18 deaths were accidental, ten deaths were suicides, seven deaths were attributed to SIDS, seven deaths were the result of natural causes, six deaths were homicides, and one death was undetermined.

Figure 7. CAO Child Death Reviews showing Cause of Death for Children Not in the Care of the Minister of Social Services, 1996-1998. N=49



Part 7
Themes and Issues

Themes Relating to Cause of Death

Sudden Infant Death Syndrome (SIDS)

"Sudden Infant Death Syndrome (SIDS) is defined as the sudden death of an infant that is unexpected by history and unexplained by a thorough postmortem examination that includes a complete autopsy, investigation of the scene of death, and review of the medical history."

Berhman, Kliegman, & Jenson, 2000.

In Saskatchewan, Sudden Infant Death Syndrome (SIDS) is the leading cause of death in infants between one month and one year of age. (Saskatchewan Institute on Prevention of Handicaps, 2000). Although the actual cause of SIDS deaths remains unknown, there has been a great deal of research that has identified relevant risk factors and risk reduction measures. Risk factors in the baby include growth failure, male gender, and prone or side sleep position. Risk factors in the mother include multiple births, smoking during pregnancy or in the baby's presence, young age, limited education, and drug exposure. Research also suggests that parents should avoid sharing beds with babies if they have been smoking, drinking alcohol or using drugs that reduce alertness (Berhman, Kliegman, Jenson, 2000).

This report includes seven infants whose deaths were attributed to SIDS. The CAO has identified the need for the development of a SIDS prevention strategy. This strategy should include a coroner's protocol for enhanced reporting of deaths where SIDS is suspected, public education for all families, and special attention for high-risk families.

The CAO also found a lack of standardized criteria by which coroners determine that a particular death was attributable to SIDS. In March 1997, "the BC Coroner's Service introduced the SIDS investigative protocol, a standard investigative checklist for coroners. This protocol ensures that apparent SIDS deaths are fully explored by police and coroners in case a more definite diagnosis is possible to explain the sudden death" (The Children's Commission, 2000). A protocol such as this in Saskatchewan could provide more accurate data, advance the prevention of the risk factors and evaluate the effectiveness of prevention programming.

Conclusion: The CAO recommended that the Coroner's Branch consider developing and implementing a SIDS protocol for use by coroners in Saskatchewan. The Chief Coroner has agreed to proceed with this initiative.

Co-sleeping/Bed Sharing

"Bedsharing is a common practice for many families. ... The risk of SIDS is increased if the person who shares the bed is a smoker, or has been consuming alcohol or taking other drugs that may decrease their responsiveness."

Health Canada, Canadian Institute of Child Health, The Canadian Foundation for the Study of Infant Deaths, Canadian Pediatric Society, 1999.

Of the 62 child deaths reviewed for this report, 11 were infants. An infant is defined as a child from birth to under one year of age. Of the 11 infants whose deaths are outlined in this report two deaths were classified as Accidental, one was classified as Natural, seven were classified as SIDS, and one was Undetermined.

Although results were inconclusive, there were clear indicators in seven of the infant deaths that an adult was sleeping with the infant at the time of the death. Most of these deaths were attributed to SIDS. There were no deaths officially attributed to co-sleeping (which is caused by asphyxia from unintentional smothering of the infant by an adult while asleep or intoxicated).

Conclusion: While it is recognized that bed-sharing is a traditional practice in many cultures and is believed to have positive benefits, it is the CAO opinion that all new parents need to receive information regarding the dangers of co-sleeping with their infant children especially if the parents are intoxicated.

The CAO wrote to the Chair of the Saskatchewan's Action Plan for Children Steering Committee (SAPC)* regarding the issue of bedsharing. The CAO asked the Steering Committee to consider reviewing what information about co-sleeping is presently available to new Saskatchewan parents and the service providers who work with these families. The CAO also asked that the Steering Committee consider ensuring that this information is available to all families. Saskatchewan Health is reviewing this request.

*(Note: SAPC is an interdepartmental initiative of the Government of Saskatchewan. It represents the co-operative effort of nine government departments and secretariats. The Saskatchewan Action Plan for Children is a provincial strategy to enhance the well-being of children, youth and families and provides a process for working together to improve the well-being of Saskatchewan children.)

Fetal Alcohol Syndrome (FAS)

Fetal Alcohol Syndrome (FAS) is a combination of mental and physical disabilities present at birth. FAS is a lifelong condition that can have devastating effects on the individuals and their family. Fetal Alcohol Syndrome is caused by maternal alcohol consumption during pregnancy.

Saskatchewan Institute on Prevention of Handicaps, 2000

It is not possible to determine how many of the children represented in this report were affected by Fetal Alcohol Syndrome or by the effects of prenatal exposure to alcohol . Based on the file recordings, the presence of FAS or the effects of prenatal exposure to alcohol was a significant concern regarding many of these children. Three of these 62 deaths were directly attributed to complications arising from FAS or the effects of prenatal exposure to alcohol, and were classified as natural deaths.

Conclusion: The CAO review of these deaths indicated a continuing need for programs to prevent the disabling conditions resulting from the effects of alcohol consumption during pregnancy.

The CAO welcomed the recent announcement by the Minister of Social Services for additional funding aimed at the prevention of FAS or the effects of prenatal exposure to alcohol and for providing increased services for children affected by these conditions.

Violence

A disturbing theme identified during these reviews was the number of children who had suffered assaults during their lives and/or who died at the hands of their family and caregivers. These deaths occurred in families for the most part characterized by violence, alcohol and substance abuse, past victimization, unemployment and poverty. These families were generally in contact with many child serving agencies and government departments. Thorough assessments and coordinated case planning is necessary to ensure that children are, most importantly, safe and that families receive the support services they need. It is clear that a collaborative approach with all child-serving agencies is required.

Of the 62 deaths reviewed, there were seven children who died as a direct result of assault. All seven of these children were identified as having suffered assaults, mainly from family members, during the course of their lives. These seven children included:

- a 26-month-old boy beaten to death by his mother's common-law spouse,
- an 18-year-old girl, raped, beaten and strangled by a male relative,
- four youths, ages 16 to 17, killed by stab wounds (two in their family homes), and
- a five-year old girl, killed by her guardian.

Criminal charges were laid by the police in all seven of these deaths. Six of these children were living with their natural families or independently when they died; one young person was receiving assistance from the DSS under a Section 10 agreement. (Section 10 Agreements are those in which the young person enters an agreement with the DSS on their own behalf. The program combines child welfare, youth services and income support for youth and provides a single entry point for services.)

In addition to the seven children who died by assault, there were 11 children which were also identified as having suffered assaults, mainly from family members, during the course of their lives. These 11 children did not die as a result of the assaults, however, the violence reflected in the CAO examination of their lives remains disturbing. These children all experienced violence in their family homes and all but three were residing with family at the time of their deaths.

Conclusion: The review of these violent deaths and the assaults on children raised a number of concerns. There continues to be a need to find ways to protect Saskatchewan children from family violence. The CAO identified to the DSS those individual deaths where a formal Safety Assessment might have been helpful in determining whether the child was at risk or in need of protection.

The CAO recommended that the DSS ensure that the policy and practice specified in the Family Centred Services Manual are complied with. In particular, the CAO recommended that the DSS take steps to ensure that children who remain in the care of their family are protected within that family unit when there are known risks to a child.

The CAO also requested that the DSS pursue discussions with the Department of Health about ongoing public education about the importance of reporting potential abuse of children to the appropriate authorities. A climate where the inclination is to report rather than to ignore must be fostered.

The DSS, Saskatchewan Health, Saskatchewan Justice, Saskatchewan Municipal Government and Saskatchewan Education, together form the Interdepartmental Child Abuse Committee. The CAO suggested that the DSS collaborate with this Committee and the College of Physicians and Surgeons, to create a strategy that provides all child-serving agencies/ institutions with information on the importance of reporting child abuse and a method which makes reporting user friendly.

The DSS has indicated to the CAO that it is reviewing the policies and practices regarding investigations of reports of abuse. The DSS has also initiated discussions with Saskatchewan Health on the duty to report suspected child abuse. The DSS is working with the Interdepartmental Child Abuse Committee to create strategies that would provide child serving agencies with this information.

Suicides

Eleven of the 62 children and youth died by suicide, either by hanging or gunshot. The youngest was an 11-year-old boy. Seven of these children had been identified as suicidal, five of which had received mental health services prior to their deaths. In two of the deaths reviewed, the children had received mental health services from their health district. In reviewing these two deaths, the CAO found a lack of information sharing and a need for collaborative case planning between the DSS and Mental Health.

Conclusion: The CAO recommended that the DSS, Saskatchewan Health and Health Districts develop a protocol to provide for collaborative case planning for children or youth who are receiving services from both the DSS and a Health District. Further, the CAO recommended that this protocol include a mechanism for review and follow-up to ensure that the needs of the child are being appropriately addressed. This recommendation is currently under consideration.

The DSS and Saskatchewan Health have responded positively to the above recommendation. Some initiatives are already in place, in particular the Integrated Case Management Program. A review of this process and discussions between the DSS and Health are ongoing.

Alcohol and Drug Use

Twelve of the 62 children were under the influence of alcohol or drugs at the time of their death. Eight of the 62 children that died were previously identified as having substance abuse problems, although not all of the eight young people accepted or accessed the addictions treatment they were offered. It should be noted that, of these eight, not all were under the influence of alcohol or drugs when they died.

There was, and continues to be, a general perception that there are difficulties for youth to access addictions services. This was further complicated by some youth refusing to comply when services were offered. In addition, a common concern was that there was limited access to culturally appropriate addictions treatment for aboriginal youth.

A report prepared by Saskatchewan Health, *An Overview of Alcohol and Drug Recovery Services for Adolescents in Saskatchewan, (February, 2000)*, states that children under the age of 18 can obtain limited outpatient treatment through health districts and through the Native Alcohol and Drug Abuse Program (NADAP) workers on First Nations reserves. There is one inpatient facility in the province for drug and alcohol treatment of both male and female youth. This facility provides service to all youth from all cultures and includes aboriginal programming. There are also two inpatient treatment centres located in First Nations communities for the specific treatment of children with solvent abuse problems. Saskatchewan Health has a procedure to provide youth with services outside of the province if the required treatment is not available in-province.

Conclusion: While valuable programming and services are available for addicted children and youth, adults in Saskatchewan have access to a greater continuum of services. Adults can attend a variety of detoxification centres, inpatient centres, structured day programs, individual outpatient treatment, as well as relapse prevention programs. The CAO is concerned that children and youth do not appear to be provided with access to the same continuum of services as adults.

Issues Relating to Service For Children

Noncompliance by the DSS to Legislated Requirements and Policy Standards

As previously stated in the General Findings section of this report, the CAO found that the services provided by the DSS to 29 of the children and their families either met or exceeded the DSS standards. However, in 32 of the files reviewed (excluding Karen Quill), case management concerns were raised with the DSS. In these 32 files, the standards and policy requirements that were in place to provide services to children were not adhered to consistently.

The DSS, in responding to the Quill Report, committed to: improved training for DSS staff; an orientation package which focuses on program philosophy, legislative requirements, policies, procedures and standards; and case management and practice expectations. The DSS further advises that steps are being taken to strengthen quality assurance and accountability mechanisms.

"A child is in need of protection where:
(c) the child is less than 12 years of age and:
  (i) there are reasonable and probable grounds to believe that:
    (A) the child has committed an act that, if the child were 12 years of age or more, would constitute an offence under the Criminal Code, the Narcotic Control Act (Canada) or Part III or Part IV of the Food and Drug Act (Canada); and
    (B) the child's parent is unable or unwilling to provide for the child's needs."

Saskatchewan, 1989. As am. by s.s. 2000.

The DSS clarified that children receiving service from the Community Living Division (outreach and residential services) are entitled to the same level of care as other children. The CAO has particular concerns regarding the level and quality of care provided to children with special needs.

Children in conflict with the law, both those charged under the *Young Offenders Act* and those under the age of 12 eligible for service under Section 11 of *The Child and Family Services Act* presented issues including the need for policy development. Concerns regarding compliance with court ordered undertakings, adequate supervision and support were raised with the DSS and are currently under review.

Conclusion: The CAO publicly released the Quill Report (1999) and the Children and Youth in Care Review (2000), both of which identified noncompliance with case practice policies as a continuing concern requiring urgent attention.

Given these earlier reports, only the most egregious cases of noncompliance with standards and policies were brought to the attention of the DSS. It is anticipated that the changes to improve practices that the DSS has introduced in the past several months will significantly reduce these practice problems.

Transfers Between the Department of Social Services and Indian Child and Family Services Agencies

There are currently 18 memorandums of agreement signed between the DSS, Indian Child and Family Service (ICFS) agencies, and Indian and Northern Affairs Canada (INAC) to deliver child welfare services to First Nations children who live on reserves. The services are provided under the authority of *The Child and Family Services Act* and administered by the ICFS agency. The majority of these agreements were in effect at the time the 62 child deaths occurred.

When a First Nations family moves between a reserve (serviced by an ICFS agency) and an off-reserve residence (serviced by a DSS Region), the family's file is required to be transferred so that service can continue with as little disruption as possible.

Within the group of 62 child deaths reviewed, there were two files that were transferred between the DSS and an ICFS agency. In addition, there were two files where the DSS and the Band (as there was no ICSF agency) shared responsibility for the services being provided to the child. This review found a lack of information-sharing and service follow-up on all four of these files. These files lacked documentation to establish whether the needs of the children were addressed.

A framework Protocol for Case Transfer was signed in 1998 between the DSS and ten ICFS agencies. Three of the four deaths identified above occurred prior to the signing of this protocol and therefore the effectiveness of this protocol as a tool to ensure that the appropriate information is shared has not been examined.

Conclusion: The CAO has commented to both the DSS and two ICFS agencies on the need for improved communications and service follow-up between those offices when First Nations families in receipt of services relocate, requiring a transfer of the file. In addition, the *Children and Youth in Care Review* recommended the establishment of a concrete process to co-ordinate services (Recommendation #5.6), and that all levels of government establish a mechanism to provide First Nations agencies the ability to monitor the care provided to its children (Recommendation #5.7).

Part 8
Issues for the Future

The CAO is committed to conducting comprehensive, multifaceted reviews. Recommendations will continue to be made to prevent child deaths and to promote increased public accountability.

In addition to the approximately 30 deaths per year that the CAO now reviews, the Indian Child and Family Services (ICFS) agencies who are providing services on reserves under *The Child and Family Services Act* have begun to advise the CAO of deaths. Similar to the DSS, these notifications are for children who die while receiving services from the ICFS agency or who have received such services in the past twelve months. The actual number of these deaths remains undetermined at this time. These child deaths deserve the same level of review as those deaths that the DSS identifies.

It has also become increasingly clear that child deaths should be reviewed by a Multi-Disciplinary Review Team (MDRT). This MDRT would consist of a team of advisors to the CAO from the medical, law enforcement, mental health and social services professions. This MDRT would provide advice to the Children's Advocate and assist with identifying systemic and cross-jurisdictional issues. The MDRT would also assist the CAO in the formulation of recommendations. The Federal/Provincial/Territorial Working Group on Child Death Review considers these MDRTs an essential element for effective reviews. In other jurisdictions, these MDRTs have promoted injury prevention programs and have recommended new laws and policies to prevent child deaths (State Child Death Review Board California, 1997).

This report centres on the deaths of a small number of Saskatchewan children and on only one aspect of their interrelationship with the larger, provincial society: the services these children received from the DSS. Although the child death reviews which form the basis of this report are limited to children who were receiving services from the DSS at the time of their death or within the previous 12 months, these reviews are a first step towards understanding and preventing the deaths of all children.

These child deaths are a sobering reminder of the need to ensure that Saskatchewan child-serving systems are effective, and that all of us respond appropriately to ensure that our children are safe and well cared for. The CAO recognizes that this important work, while difficult, provides an opportunity to reflect upon the services children receive and to promote improvements to services that may prevent similar deaths in the future.

It is clear that much work needs to be done by all child-serving agencies to better protect our children, not only from preventable deaths but also from preventable conditions such as FAS.

These children are lost to us; they are irreplaceable. Let us learn what we can from their untimely, often tragic deaths and work to benefit future children.

Appendices & References

Appendix A	Provincial/CAO Comparison of Child Deaths
Appendix B	Review of DSS Actions on the Recommendations from the Report on the Death of Karen Quill
Appendix C	Summary of Recommendations *Children and Youth in Care Review: LISTEN to Their Voices*

APPENDIX A

Provincial/CAO Comparison of Child Deaths

Table 1. Deaths of Children From Birth to 21 Years of Age in Saskatchewan: CAO Deaths Reviewed[1] and Total Provincial Deaths[2], 1997, 1998

Official Classification of Death	Year	Age Group												TOTAL	
		Less than One Year		1-5 Years		6-11 Years		12-15 Years		16-17 Years		18-21 Years		Birth to 21 Years	
		Total Deaths	Deaths Reviewed by CAO	Total Deaths	Deaths Reviewed by CAO	Total Deaths	Deaths Reviewed by CAO	Total Deaths	Deaths Reviewed by CAO	Total Deaths	Deaths Reviewed by CAO	Total Deaths	Deaths Reviewed by CAO	Total Deaths	Deaths Reviewed by CAO
Natural	1997	82	—	12	1	5	1	12	—	4	—	6	—	121	2
	1998	72	1	13	2	8	4	4	2	4	—	14	2	115	11
SIDS[3]	1997	10	4	—	—	—	—	—	—	—	—	—	—	10	4
	1998	13	3	—	—	—	—	—	—	—	—	—	—	13	3
Accidental	1997	3	1	9	4	13	3	11	—	14	3	26	—	76	11
	1998	1	1	10	—	5	1	5	2	6	1	29	3	56	8
Suicide	1997	—	—	—	—	2	1	4	2	2	2	11	1	19	6
	1998	—	—	—	—	—	—	1	1	6	—	18	2	25	3
Homicide	1997	—	—	1	2	2	—	2	—	—	—	1	—	6	2
	1998	—	—	—	—	—	—	—	—	2	4	3	1	5	5
Undetermined	1997	—	—	—	—	—	—	—	—	—	—	—	—	0	0
	1998	—	1	—	—	—	1	—	—	—	—	—	—	0	2
Other Violence	1997	1	—	1	—	—	—	—	—	—	—	—	—	2	0
	1998	—	—	—	—	—	—	1	—	—	—	—	—	1	0
Total	**1997**	**96**	**5**	**23**	**7**	**22**	**5**	**29**	**2**	**20**	**5**	**44**	**1**	**234**	**25**
	1998	**86**	**6**	**23**	**2**	**13**	**6**	**11**	**5**	**18**	**5**	**64**	**8**	**215**	**32**

[1] Not Including the four deaths which occurred in 1996 and the death of one youth which occurred in 1998 where the youth was over age 21 but still receiving services from the DSS.
[2] Source: Saskatchewan Health, Corporate Information and Technology Branch (Table prepared with the assistance of the Saskatchewan Institute on Prevention of Handicaps, 2000.)
[3] For provincial data, includes sudden deaths of infants, cause unknown.

NOTE: A discrepancy occurred for the Homicide deaths of children aged 1-5 years in 1997 and aged 16-17 years in 1998 and for Undetermined deaths for children less than one year and 6-11 years.
Inconsistencies can arise when data from two different sources are compared. The series of deaths reviewed by the Chief Coroner and the CAO and the data from Vital Statistics are not the same data files. Some factors that may contribute to inconsistencies in data are:

Potential differences in the level of detailed analysis used by the Coroner and Vital Statistics.

Potential differences in the methods of classification used. The underlying cause may differ according to other factors relating to the person and circumstances of death. For example, a person who has an illness such as cancer may die in a fall, and the underlying cause will be cancer rather than fall.

Potential unavailability of information. In some cases a death may not be entered into Vital Statistics records because the personal information may not have been available.

APPENDIX B

Review of DSS Actions on the Recommendations from the Report on the Death of Karen Quill

The following section is a brief synopsis of the DSS response to the recommendations from the Report on the Death of Karen Quill, presented to the Minister of Social Services in June 1998.

The information has been organized in keeping with two progress reports to the Children's Advocate Office, February 3, 1999 and December 2, 1999 by the DSS in which they detail the progress they have made on the recommendations.

These recommendations were also presented in the following format in the *Children and Youth in Care Review: LISTEN to Their Voices,* published in April 2000 by the Children's Advocate Office.

Issue I:
Improving Foster Care

Recommendations identified in this area: 10, 11, 12, 13, 15, 22, and 24

"The Children's Advocate report on Karen's death identified concerns in a number of areas regarding out-of-home care for children. These focused on:

a. The number of children placed in a foster home and support for foster families to care for the children placed in their home.
b. Ongoing evaluation of foster homes to assess the foster family's ability to care for children in their care." (Saskatchewan Social Services Progress Report, February 1999).

Recommendation #10
That for every foster home application, including applications to reopen a home, a formal homestudy process be completed unless the home has been granted a pre-approved leave of absence from fostering.

Recommendation #11
That the number of children approved for placement in a particular foster home by the foster homestudy and/or annual foster home review not be exceeded. It must be recognized that each foster home is approved for a defined number or age of children. This number of children may be less than the maximum number of children allowed according to DSS policy.

Recommendation #12
That the DSS establish an effective system of accountability to ensure that the allowable number of children placed in foster homes is not violated.

Recommendation #13
That the DSS amend their current policy to ensure that multiple exceptions to the standard regarding the number of children per foster home are not permitted.

Recommendation #15
That the DSS establish measurable standards that ensure adequate support is provided to foster parents and that foster parents are informed of all available resources.

Recommendation #22
That the DSS immediately review all foster care placements and that where the numbers of children in a foster home exceed the maximum of four children, ensure that the placements are acceptable and that all necessary supports are provided to foster parents.

Recommendation #24
That the DSS immediately inform all foster parents that home support is available to assist them with providing appropriate care to the children in their homes.

TABLE 2: Actions Reported by DSS to Recommendations Regarding Improving Foster Care

Actions Reported February 1999	Actions Reported December 1999
In June, 1998 all existing placements of children in foster homes were reviewed and where there were more than four children in a home, an assessment was completed. Proper approvals for exceeding the limit were introduced.	The Saskatchewan. Foster Families Association received funding to employ two more foster home support staff. No further action on this recommendation.
An automated process was developed to identify when a foster family had more than four children and, using a strict approval process, these situations are now automatically brought forward for review every 14 days. Staff were provided training in this new approval procedure.	No further action on this recommendation.
An ongoing foster family recruitment campaign to be developed and implemented in 1999.	The recruitment campaign is still being developed. Display ads are prepared, including an appeal to Metis and First Nations families to apply and a poster has been developed to increase public awareness; a recruitment brochure has been drafted and a presentation package prepared to ensure consistent messages to the public from DSS staff.
All foster homes are to have annual reviews completed by June, 1999.	As of June 1999, DSS reported that all foster families had an annual review completed. Policies are now in place to reinforce compliance with policies.
A new respite policy was introduced that allows foster families up to five days of leave from fostering per year.	Foster families have been provided with information about the respite policy and most are reported to be accessing respite.
	Counselling for foster families is now available under certain circumstances as outlined in policy. The foster family training curriculum is being reviewed and foster families have been offered increased training on the importance of maintaining a child's connections to his or her family.

Issue II:
Improving Case Practice:

Recommendations identified in this area: 4, 5, 6, 7, 10, 11, 12, 13, 16, 17, 18, 22, 23

"The department has policy and procedure manuals that are intended to provide staff with detailed direction and guidance on how the programs are to be delivered. There are several factors that influence compliance with policies including:

- Staff must have sufficient time to carry out their responsibilities.
- Staff must be aware of, and understand, existing legislation and policy.
- Staff must have the necessary knowledge and practice skills to implement the policy.
- Staff require direction and guidance from supervisors on how to effectively apply the policies." (Saskatchewan Social Services Progress Report, February 1999)

Recommendation #4
That standards be developed to ensure that all children have a personal visit by a social worker, in the foster home in which they have been placed, within the first 48 hours of placement.

Recommendation #5
That the present policy stipulation that contact be "a minimum of twice per month for the first two months" also state that the contacts occur in the foster home in which the child has been placed.

Recommendation #6
That all transfers of children between emergency homes and longer term foster home placements be done by DSS workers and not left to foster parents or contract workers.

Recommendation #7
That a standard process be established to ensure that parents and children receive a complete explanation of the terms and conditions of their relationship with the DSS, including appeal options.

Recommendation #10, 11, 12, 13 – Listed Under Issue I.

Recommendation #16
That the DSS establish minimum standards regarding contacts and home visits with foster parents. The ongoing capacity of a foster parent to care for the children in his/her care must be assessed on a regular basis.

Recommendation #17
That the DSS ensure that all complaints concerning the treatment of children in care are completely and promptly investigated and that an accountability process be implemented which monitors DSS follow-up of these complaints.

Recommendation #18
That the DSS develop a policy regarding post death services to DSS clients, including families and foster families of any child who dies as per the DSS Death of Child or Youth Policy.

Recommendation #22 – Listed Under Issue I.

Recommendation #23
That the DSS immediately review with all staff the contact standards regarding personal contact by DSS workers with children in foster care.

TABLE 3: Actions Reported by DSS to Recommendations Regarding Improving Case Practice

Actions Reported February 1999	Actions Reported December 1999
DSS reported that 50 new staff positions were added to the department in early 1998, 43 of them were allocated to child welfare.	Internal case audits are to be conducted in each DSS office to ensure compliance with policy and standards. All 50 new positions added to child welfare by June 1999. An evaluation of the impact of these positions is being incorporated into a project looking at outcome measures in child welfare services.
Policy was changed to include a requirement that children in foster care must have a personal contact with their caseworker within two working days of placement; that the majority of meetings between the caseworker and the child should occur in the caregiver's home and that DSS staff will transport the child to the caregiver's home.	Case audits are now required by policy. All regions will have completed audits by the end of March, 2000.
Policies regarding approval of foster homes include standards related to the evolving capacities of the foster family.	No further action reported.
The Maximum Number of Children in a Foster Home policy was revised to include tracking of the number of children in a home and to clarify when more than four children in a foster home is allowed.	No further action reported.
A new Foster Home Study is now required when families reapply to become foster parents.	No further action reported.
Caseworkers are required to provide families with information about their rights to appeal administrative decisions made in family services matters.	No further action reported.

TABLE 3: Actions Reported by DSS to Recommendations Regarding Improving Case Practice (CONTINUED)

Policy regarding the investigating of allegations of abuse or neglect in foster homes is being reviewed and will include standards and follow-up requirements.	A revised policy has been implemented that provides practice guidelines and outlines a process to ensure consistency in addressing complaints. In addition, a database has been developed to maintain information about allegations of abuse or neglect in a foster home and actions taken following an investigation.
Foster families are provided up to five days of paid respite.	No further action reported.
Policies will include the need to assess and provide services for the family, the caregiver, other children and DSS staff after a child death.	No further action reported.
The Children's Services Manual is being completely revised, in consultation with DSS staff and other stakeholders. To be completed and available for staff and FNCFS agencies in September, 1999.	The new Children's Services Manual has been drafted with the guidance of a reference group including caseworkers, supervisors, DSS management staff, foster families and Youth in Care. A finalized version is expected in 2000. A new Assessment and Case Plan format will be introduced in 2000. Child development, family resources and other areas will be assessed and incorporated into a child's case plan.

Issue III: Improving Out-of-Home Care for Children

"These recommendations...noted concerns that there were insufficient foster homes and other out-of-home care resources for children, and that extended family should be considered as the priority resource for children who cannot be cared for by their parents." (Saskatchewan Social Services Progress Report, February 1999).

Recommendation #1

That when a First Nations child is apprehended by the DSS, all possible placement options must be explored with the Band/Agency prior to placing the child in the DSS (non-emergency) foster care system. This necessitates that the DSS and the Band/Agency develop a process to ensure that this exploration of placement options takes place.

Recommendation #2

That all possible caregivers for children, especially extended family members, must be considered as placement options, where it is safe to do so, particularly when children are already in emergency foster care.

Recommendation #3

That an effective and accountable system be developed that ensures extended family members are considered as placement resources and that a record of the outcomes be documented.

Recommendation #8

That parents of children who are in foster care under a voluntary agreement be provided with resources and support to facilitate their children being returned to them in a timely and safe manner.

TABLE 4: Actions Reported by DSS to Recommendations Regarding Improving Out-of-Home Care for Children

Actions Reported February 1999	Actions Reported December 1999
DSS and the FNCFS agencies are working together to improve services for First Nations children and their families. Actions have included providing training to FNCFSA foster care resource coordinators and developing protocols to transfer responsibility for child welfare services to the FNCFS agencies.	Contact between First Nations Child and Family Services Directors and DSS occurs on an ad hoc basis. Local forums have been established in some, but not all locations. New North and Family and Youth Services, DSS are working to address a number of concerns specific to child welfare services in northern communities.
DSS revised the Family Connections program to increase their work with FNCFSA and other First Nations agencies and with Metis organizations to assist with identifying extended family at an early stage in a child's admission to care.	The role of the Family Connections staff continues to emphasize the need to identify and facilitate extended family and cultural community connections for children in care. Regions that do not have a Family Connections Coordinator are taking steps to establish them.
DSS reported that more supports, such as parent education, counselling, day care or in-home supports, were provided to families to prevent children from being placed out-of-home.	No further action reported.
DSS expanded services for high needs children and youth by providing additional funding for therapeutic foster care and by creating additional spaces for residential treatment of children in care. These additional residential treatment programs include two pilot projects in Prince Albert and a 16-bed facility in Saskatoon.	Placement options for children and youth in care have been examined in three of the six Social Services regions. Significant new placement resources for older children have been added.

Issue IV:
Improving Training and Communication:

Recommendations identified in this area: 9, 14, 25, 26, 27

"The Children's Advocate report identified the need for staff to be well trained in child welfare programs. The report advised the department to establish employee training programs and continuing professional education programs. The report noted the importance of organizational structures that supported communication and effective casework. The Children's Advocate recommended that, wherever possible, each family receive services from a single case worker." (Saskatchewan Social Services Progress Report, February 1999).

Recommendation #9
That children should be in foster care on apprehended status only under circumstances which are enumerated under *The Child and Family Services Act*. Case planning must occur in a timely fashion.

Recommendation #14
That the DSS provide resources and organizational support to children in foster care to ensure that the care provided to these children is consistent with safe and appropriate case management practices.

Recommendation #25
That the DSS establish a comprehensive, new employee training program which must be completed by new employees before they assume responsibility for child protection or child care services.

Recommendation #26
That the DSS establish a comprehensive continuing professional education program that ensures all DSS workers receive a minimum standard of ongoing professional development.

Recommendation #27
That children in care and their families receive services, where possible, from one clearly identified case manager who is responsible for ensuring that the children receive quality services in a timely and coordinated manner.

TABLE 5: Actions Reported by DSS to Recommendations Regarding Improving Training and Communication

Actions Reported February 1999	Actions Reported December 1999
By March 1999, all new staff hired in child welfare services were to receive a standard orientation. This orientation was to occur within the first eight weeks of their employment.	A Child Welfare Orientation package has been provided to all supervisors who will use it to train new employees within the first eight to 12 weeks of their employment.
Four trainers were hired to work with the two existing trainers to implement a child welfare curriculum. The training includes classroom instructions and support with daily practice of case workers. All child welfare staff will receive this training.	A strategy to deliver training over the next three years has been developed. About 280 staff have been trained, including FNCFS staff. The strategy includes a regular training schedule so that new employees will be trained in a timely manner. Supervisors have received additional training on effective supervision.
Organizational structures in regional offices were reviewed with attention to how caseworkers communicated between units and with children, families and foster families. Some reassignment occurred that was intended to improve workflow and communications.	No further action on this recommendation.

Issue V:
Other Recommendations:

Recommendations identified in this area: 19, 20, 21

Recommendation #19
That the emotional and behavioural needs of the children present in the foster home at the time of Karen's death be assessed and that any recommendations arising from these assessments be acted upon.

"This recommendation required the department to assess the behavioural needs of the other children present in the foster home at the time of Karen Quill's death and to follow up on any suggested treatment." (Saskatchewan Social Services Progress Report, February 1999)

Action: DSS reported that required services were provided to the children and that they continue to monitor and support the children as needed.

Recommendation #20
That child deaths under investigation by all police services be referred to Public Prosecutions for a legal opinion.

"This recommendation reflects concern that there be a better understanding of potential criminal liability in instances of child death." (Saskatchewan Social Services Progress Report, February 1999)

Action: Saskatchewan Justice and police services have reviewed practices and are working together to increase communications during any investigation of a child death.

Recommendation #21
That the Child Death Advisory Committee, chaired by the Children's Advocate, review and clarify terminology used by various agencies to ensure understanding and, where possible, consistency.

"This recommendation advises the Child Death Advisory Committee to review and clarify the terminology used by various agencies to ensure understanding and, where possible, consistency." (Saskatchewan Social Services Progress Report, February 1999)

Action: The Child Death Advisory Committee, chaired by the Children's Advocate, has reviewed the terminology with key agencies. Increased clarification of terms has emerged. In addition, the Saskatchewan Children's Advocate and the Chief Coroner are participating in a national network of organizations that independently review child deaths. Establishing a common terminology is one goal of this national network.

APPENDIX C

Summary of Recommendations from the *Children and Youth in Care Review: LISTEN to Their Voices*

RECOMMENDATION 1

That all government departments and agencies provide children and youth with a right to participate in planning for their care.

Recommendation 1.1

The Child and Family Services Act be amended to include participation rights for children in care. This includes the right to:

- be informed about their plans of care;
- an interpreter if language is a barrier to consulting with the child;
- be informed about and assisted in contacting the Children's Advocate;
- be consulted and to express their views, according to their abilities, about significant decisions affecting them;
- be informed of their rights and of the procedures available to them for enforcing their rights.

Recommendation 1.2

That a youth in and from care advisory network be established to provide support to youth in and from care and to advise government on policies and practices that impact children and youth in care. Sufficient and sustained resources and support must be provided to this youth participation process.

RECOMMENDATION 2

That every child in care has a comprehensive, child-based plan of care that recognizes the importance of stability in the child's life and that honours the continued involvement of family, extended family and community.

Recommendation 2.1

That the Minister of Social Services provide DSS staff with the training, support and time needed to carry out their obligations as outlined in policy and best practice standards.

Recommendation 2.2

That a mandatory, extensive orientation and training program be completed by all new employees BEFORE they assume responsibility for child protection or childcare services. DSS workers must be given sufficient orientation and training to ensure that they know and understand their responsibilities.

Recommendation 2.3

That ongoing professional development be supported for all family services workers.

Recommendation 2.4

That the DSS workers and supervisors are provided with sufficient time and resources to meet the standards outlined in policy and legislation. This includes meeting the best practice expectations that are clearly outlined in the *Family Centred Case Management Policies* and meeting all of the standards of care for children that are articulated in various other policies. In order to meet this recommendation, DSS must ensure that there are adequate resources available AND that individual DSS workers and supervisors are providing services in a respectful, ethical manner.

Recommendation 2.5

That every child in care has a clearly articulated and documented care plan. This plan must be reviewed and monitored systematically. Children, family members and community members, particularly First Nations or Metis Nation representatives, where appropriate, must be included in the development of the care plan and must participate in the regular reviews of the care plans.

Recommendation 2.6

That every effort be taken to support a child to live and grow up in a stable environment. There must be a procedure established to review every move a child experiences preferably before the move occurs. Reasons for every move must be clearly documented. A clear accountability system must be established to protect children from being frequently moved to another setting as a solution to a problem.

Recommendation 2.7

That the DSS and First Nations governments review the impact that long-term care orders in conjunction with adoption policies are having on the lives of children who are long-term wards and being raised in foster care. The growing number of young children who are now long-term wards is alarming.

Recommendation 2.8

That children in care have up-to-date, accurate records that provide complete information about all aspects of the care they are receiving. These records must include a detailed plan for care that incorporates health and educational status. Children must also have access to the personal information that is kept about them.

Recommendation 2.9

That foster parents must be provided with information about the children in their care in a timely manner. Health status, education, family connections and other information useful to providing daily care is required by foster parents as soon as possible.

Recommendation 2.10
That the DSS data collection be reviewed and updated to ensure that accurate and timely statistical information about children in care is available. It would be useful for all government departments and agencies that provide support to children in care, including Health, Education and the FNCFSA to have some mechanism to evaluate the impact of the programs/services that are being provided to children in care and their families.

Recommendation 2.11
That connections between a child in care and his or her family and extended family are made as early as possible and supported to the maximum extent. Children should not drift within the foster care system without every effort being made to connect them in a meaningful way with their family of origin.

Recommendation 2.12
That older youth in care be supported in their transition to independent living. Community standards of parenting and regulations that all Saskatchewan parents must comply with must also be applied to government as parent.

RECOMMENDATION 3

That foster families, Persons of Sufficient Interest and Alternate Caregivers be provided the supports they need to ensure that the children in their care are provided, to the maximum extent possible, the special protection and care to which they are entitled.

Recommendation 3.1
That kinship or extended family care arrangements be considered for every child who comes into care. DSS workers must be provided the support and resources to actualize these arrangements.

Recommendation 3.2
That policies regarding Persons of Sufficient Interest (PSI) and Alternative Caregivers be reviewed to ensure that these placements are supported in a fair and consistent manner throughout the province. The policy must include direction regarding PSI/Alternate Caregiver fees. Special needs funding for PSI/Alternate Caregivers must be provided at an equivalent rate to that provided to foster parents. There is also a need to clarify how the Child Tax Benefit/Child Tax Credit is allocated when a child is in care with a PSI or Alternate Caregiver.

Recommendation 3.3
That more First Nations and Metis Nation foster families be recruited and trained, preferably by persons of Aboriginal ancestry.

Recommendation 3.4
That the DSS develop a strategy for a continuous foster home recruitment and screening program.

Recommendation 3.5
That compensation rates for foster parents be reviewed in relation to rates of pay for other in-home care providers, such as Community Home Operators, Approved Home Operators (with Mental Health) and Personal Care Home Providers (Long-Term Health Care) that are funded by the provincial government. Foster parents should be paid at an equivalent level to other out-of-home care providers.

Recommendation 3.6
That all foster parents participate in the required training before children are placed in their home.

Recommendation 3.7
That continuous and reasonable financial support, including babysitting and respite, be provided to all foster families.

Recommendation 3.8
That the protocols used to review and investigate allegations of foster family abuse, the death of a child in a foster home and complaints from foster children be adhered to. Protocols must ensure that children are safe and listened to, while ensuring that children and youth, foster family members, natural family members, and DSS workers are treated fairly and supported with compassion.

Recommendation 3.9
That more resources such as small, local group homes be developed throughout the province, particularly in northern or more remote communities.

Recommendation 3.10
That the model used in the Therapeutic Foster Home Program be extended to all foster homes, particularly with regards to training, support, and respite services.

RECOMMENDATION 4

That formal decisions about children in care and their families are timely and that fair procedures are in place for all people involved, including the children, their parents, the foster parents and the DSS staff.

Recommendation 4.1
That the Minister of Social Services provide community and family members with opportunities outside of the judicial system to formally influence care plans for children and to participate in a review of administrative decisions that affect children in care and their families.

Recommendation 4.2
That the Family Review Panels and Family Services Board be established, either as currently defined in *The Child and Family Services Act* or through an amendment that defines responsibilities more broadly. These Review Panels should include community members in the review of care plans for children and families and provide an independent, community-based appeal procedure for children and others who have concerns about administrative decisions made by the Department of Social Services (DSS).

Recommendation 4.3

That the timely introduction of a skilled and neutral mediator, as provided for in *The Child and Family Services Act*, be considered more frequently. The mediator must be from outside the child protection system and be involved only when families and workers volunteer to participate in this process. The objective of such mediation is to help the child welfare officials, the parents and the child come to an agreement on a plan that is in the best interests of the child, while removing the power imbalance that frequently occurs between the child protection workers and families. The DSS worker and the mediator are not the same person when formal mediation is determined to be the most useful approach to resolving an issue.

Recommendation 4.4

That the DSS, in conjunction with the Department of Justice, review the time limits outlined in The Child and Family Services Act. Amendments to the Act and changes in practice should be considered to ensure that both the time taken in getting a case dealt with in the courts and the length of time a child can be in care without a permanent resolution are meaningful and can be adhered to.

RECOMMENDATION 5

That all government departments and agencies that serve children and families make the needs of children who live in foster care or other out-of-home placements a priority. The supports needed to assist these children are not only the responsibility of the Minister of Social Services. All children, particularly those whose parent is essentially the government, deserve the same access to Health, Education, Justice and other government services as children who live with their natural families.

Recommendation 5.1

That government departments and agencies that serve children and families, in particular Social Services, Health, Education and Justice with First Nations and Metis Nation agencies establish a concrete mechanism to coordinate services in the interests of the children being served.

Recommendation 5.2

Children who are in care under the supervision of the Community Living Division, DSS must be provided care under the same policies as other children in care. Additional supports may be needed for these children, however, at minimum they should receive equivalent services.

Recommendation 5.3

That the Department of Social Services and District Health, Mental Health Child and Youth Services develop concrete plans to ensure better coordination of services and the enhancement of cooperation at all levels of the two systems.

Recommendation 5.4

That children in care have their health needs carefully assessed, monitored and fully documented. The full range of health services that parents provide to their children must be maintained by government as parent, including regular health check-ups, up-to-date immunizations, dental check-ups and follow-up, as well as any specialized care required, such as eyeglasses, mental health counselling or orthodontic work.

Recommendation 5.5

That every child care plan must include a plan to ensure that the educational needs of that child are being met, including special educational needs of hard to serve children. The Minister of Education has a responsibility to provide children in care with an appropriate education. There must be careful documentation of all education progress to ensure continuity when children move or are returned home. Social Services and Education must coordinate efforts to ensure that the educational needs of children in care are a priority.

Recommendation 5.6

That the care plan for every First Nations child in care be carefully coordinated between DSS and the First Nations Child and Family Services Agencies (FNCFSA). Transfer of responsibility from DSS to FNCFSA is occurring throughout the province at varying rates and with a variety of procedures, each specific to the Agencies involved. This creates confusion and stress which must be resolved in order to better support the children and families who require support.

Recommendation 5.7

That the First Nations, provincial and federal governments establish a mechanism that, at minimum, provides the First Nations Agency the resources and authority to monitor the care provided to child members of their First Nation who are in the care of DSS and live off-reserve. First Nations children and families living off-reserve need prevention services and mandated child protection and child care services to be connected in some formal way to their First Nation.

Recommendation 5.8

That the Department of Social Services work with the Metis Nation to establish a formal mechanism that will provide for the inclusion of the Metis Nation in planning for Metis children in care.

RECOMMENDATION 6

That all provincial government departments and agencies that provide services to families, particularly those involved in the child welfare system, undertake to provide to the maximum extent of their resources supports to help families out of poverty.

Recommendation 6.1

That the federal and provincial governments, in collaboration with community organizations, determine how poverty impacts on children and families involved in the child welfare system and develop effective strategies to address this issue.

Recommendation 6.2

That the financial assistance provided to families be reviewed and adjusted to more adequately reflect the needs of children, particularly those living in the north.

Recommendation 6.3

That an action plan to eliminate housing shortages in northern Saskatchewan and inner-city areas be developed with clearly articulated short and long-term goals.

Recommendation 6.4

That access to addictions services, child development, parenting assistance, and health care services is timely and coordinated between various service sectors.

Recommendation 6.5

That the Minister of Health, in collaboration with other key partners, ensure support to children and families in the prenatal and neonatal period. This support must also be sustained throughout early childhood.

Recommendation 6.6

That the Minister of Social Services ensure that quality childcare is available and affordable for all families, particularly vulnerable families that may not qualify for a child care subsidy.

RECOMMENDATION 7

That provincial government departments and agencies establish a broad-based community approach to child welfare.

Recommendation 7.1

That a community-based child welfare advisory panel be established to monitor the implementation of the recommendations contained in this report. It is strongly recommended that government departments report to this advisory panel on a regular basis for up to five years on the progress they are making towards meeting the recommendations made in this report. This Panel could also consult and advise government on all aspects of policy and practices as these relate to children and families involved in the child welfare system.

Recommendation 7.2

That "community-based" be defined as including children and youth in or from care; parents whose children are or were in care; First Nations and Metis Nation representatives; foster parents; social workers from the "frontline"; other professionals, such as health care providers and educators.

Recommendation 7.3

That the Minister of Social Services not be left to assume full government responsibility for children and families who are at risk of or are already involved in the child welfare system. There is a responsibility across government sectors and in communities to find effective solutions to the issues. The child welfare sector does not and cannot act in isolation from the rest of the community—children and youth are a collective responsibility of all of us.

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